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Abstract

This paper discusses the process of relapse and factors in preventing relapse with Deaf persons. Barriers to recovery are examined as well as factors that contribute to recovery. Relapse prevention materials and services are discussed. Results of a follow up study of Deaf individuals who completed treatment at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals are provided along with recommendations for promoting recovery.

Introduction

Service providers need to learn about relapse and its prevention as more options become available for Deaf people who recognize a problem and seek treatment for addiction to alcohol and other drugs. Individuals who complete treatment are only beginning the road to recovery. Recovery entails a great deal of work after treatment and should be encouraged by ongoing support and education. Hearing people often have many options for getting this kind of support including counseling and self help groups like Alcoholics Anonymous as well as a large recovering community. Deaf people, on the other hand, often find local sources of support to be inaccessible due to communication barriers and the small number of recovering Deaf people.

Families, friends and service providers would be better able to provide support to recovering Deaf persons if they understood the processes of addiction, recovery and relapse. This paper will focus on the process of relapse and how it relates to the process of recovery. By knowing the process of relapse, concerned persons may be able to detect warning signs and intervene in this process. Likewise, it is important to have the recovering individual understand the process of relapse and to be actively involved in prevention efforts on his or her own behalf.

In addition to the process and the warning signs, this article will look at factors that seem to contribute to ongoing recovery in the cases of Deaf clients who have completed treatment at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. The authors will identify those variables that seem to be present in individuals who achieve longer periods of sobriety or abstinence and absent in those individuals who have been unable to continue a recovering lifestyle.

Relapse Definition

Gorski and Miller (1986) describe the evolution of the current understanding of relapse. In the 1930's relapse was thought to be simply the resumed use of alcohol. But as alcoholics began substituting the use of other sedative drugs for alcohol, there was a recognition that an alcoholic cannot safely use any sedative drug. Relapse was thought of in terms of the resumption of any sedative use, including but not limited to alcohol. As the use of a variety of drugs became more common in the '60's, there was an awareness of the ability of any mood altering chemical to trigger relapse. The effects of LSD, marijuana, cocaine and other drugs may differ from alcohol and other sedatives. However, they have the same behavioral effect in that they relieve pain now but cause pain later, and result in loss of control. By recognizing that recovery requires more than just abstinence from alcohol and other drugs, one may also recognize that relapse also is more complex than the simple act of taking a drink or a drug. Now it has become clear to the recovering community and to treatment providers that relapse is not defined by the single event of using a chemical but may more properly be thought of as the process of becoming dysfunctional in one's sobriety. In other words, the process of relapse begins before the actual addictive use and the dysfunction will likely involve one's physical, emotional, psychological or social health .

Relapse is more than just the return to drinking or other drug use. It is no longer accurate to think of relapse as the return to "loss of control drinking", triggered by the ingestion of the first one or two drinks. The acceptance of psychological and social factors are important in precipitating the first use but also in maintaining the pattern of use after this point (Marlatt, 1978).

The Relapse Process

Gorski and Miller (1986, pp. 139-156) describe the relapse syndrome as a series of phases with warning signs that ultimately lead to the resumed use of mood altering chemicals. This syndrome begins with a phase of Internal Dysfunction involving thought impairment, emotional impairment, memory problems, high stress, sleep problems and coordination problems. The alcoholic or addict experiences shame and guilt as a result of the inability to manage these warning signs and develops a sense of hopelessness. The second phase is External Dysfunction involving a return to denial, avoidance and defensiveness, crisis building with personal problems, a stage of immobilization and finally confusion and overreaction. Next comes the loss of control phase involving depression, loss of behavioral control, recognition of the loss of control,

and a feeling of being trapped with the only alternatives seeming to be insanity, suicide or addictive use. The actual return to addictive use often follows closely on the heels of these phases and signs.

With the identification of these phases and signs of the relapse process comes the opportunity to intervene in the process prior to the actual resumed use of mood altering chemicals. As with the addiction, the recovering person is often not able to detect the various signs of relapse. It is especially important that there be supportive individuals who can point out various warning signs to the recovering person. With Deaf persons, the availability of support persons may be fewer because of the communication issues. Instead of the vast number of choices of Twelve Step meetings and members, the recovering Deaf person may have only one or two interpreted meetings and a smaller number of AA or NA members with whom he or she can communicate. Wentzer and Dhir (1986) refer to the recovering group within the Deaf Community as "microscopic" in size. Whitehouse (1991) suggests that there are few professionals nationally in helping roles who are versed in chemical dependency as well as necessary communication, psychological, social and cultural dimensions of Deafness. Professionals providing services, family, friends and members of the Deaf Community can all provide helpful feedback that can help the recovering Deaf or hard of hearing individual prevent or arrest a relapse.

Factors in Preventing Relapse

In the field of chemical dependency, many ideas have been put forth concerning indicators of long term sobriety success and the prevention of relapse. It has been suggested that routine follow up by Employee Assistance program staff can result in reduced frequency of relapse (Foote and Erfurt, 1991). One study suggests that patients at a higher risk of relapse request more medication for subjective symptoms during treatment than do their peers who are more likely to remain abstinent (Heer and Marshall, 1993). A report of the Maudsley Relapse Study of 1978 identifies the following more prominent relapse factors: negative mood states such as boredom and anxiety; cognitive factors including deliberate decisions to use again; and a range of environmental factors including unsatisfactory home environment (Gossop, 1992). Mudsley (1978) further identified a number of protective factors including persons, activities and social structures that were identified by the recovering person as being helpful to them. Even the use of codeine for relief of non-life threatening conditions may pose an unacceptable risk to the addict's recovery (Stock, 1991).

Treatment Follow up with Deaf Persons

A study done with Deaf clients from the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (MCDPDHHI) addresses some factors that may contribute to successful treatment and recovery for Deaf persons (Guthmann, 1995). The MCDPDHHI (the Program) is an inpatient treatment program that is hospital based and follows a Twelve Step philosophy. Its clients are Deaf individuals from across the United States and Canada in an environment that is sensitive to the communication and cultural needs of this population. The study was done as a follow up to treatment services received at the Minnesota Program to understand what components contributed to sobriety after clients were discharged. As of September, 2001, the Minnesota Program had served over 800 clients from throughout the United States and Canada. A total of 112 contacts and interviews were conducted with former clients of the Program as part of the treatment follow-up. Each client was contacted using a survey that was designed to include an emphasis on the following areas: length of sobriety, current use of alcohol/other drugs, use of self-help groups, client satisfaction with the Program and quality of life since treatment.

At the time of the survey, 64 of the clients reported being sober; 8 were not sure of their status (some information comes from referral sources, family and other persons involved with the client) and 40 indicated that they had relapsed. The last reported use of mood altering chemicals ranged from one week to six months. Related specifically to alcohol use, 48 individuals reported no use, 15 reported weekly use. Daily use was reported by 10 individuals. However, 69 of the individuals contacted reported no use of marijuana.

When former clients were asked about support for their recovery, 34 of the clients reported some contact with a sponsor from a Twelve Step program. Many also reported getting support in their recovery from family and friends. Sixty-three of clients reported some attendance at AA/NA meetings ranging from daily to monthly. Fifty of the respondents indicated participation in individual counseling and only 17 were involved in some kind of family counseling. These responses are lower than one would expect to find in the hearing community where there is full access to a continuum of aftercare services and may be indicative of the difficulty still faced by Deaf persons in accessing traditional support for recovery. Sponsors who are Deaf, hard of hearing or who can communicate in sign language continue to be difficult to find. Accessible Twelve Step meetings have become more available in large metropolitan communities but continue to be seriously lacking or nonexistent in other communities. The

situation seems to be similar related to agencies or individuals who are able to provide accessible counseling services.

Eighty-seven of the individuals reported that they perceived their treatment as having contributed to their success in achieving sobriety. Seventy-nine percent also reported the belief that their problems prior to treatment were related to their use of alcohol/drugs. After treatment, most of the respondents indicated a general improvement with specific improvement in various life areas: 67 reported improvement in home/school/work; 71 reported improvement related to family/friends; 58 reported financial improvements; 74 reported improvements in the area of health. Forty-nine of the clients indicated that they have changed friends since treatment.

In the areas of employment, responses were largely negative with the majority of the former clients (57) continuing to be unemployed. Most were also not in school. A number of these former clients (25) continued to live at home with their parents or other relatives even though all were adults. Even when the client had relapsed and returned to negative behaviors such as abuse, theft and lack of respect, he/she was allowed to continue to remain in a family member's home. As previously stated, there appears to be only minimal use of family therapy in these situations. This information seems to point to the need for ongoing sharing of information with family members, friends and professionals who work with Deaf people who are chemically dependent. Changes in these systems (family, school, work, social services) could help encourage clients to utilize the information and skills learned in treatment.

This study seems to reinforce the idea that traditional sources of support and encouragement for hearing people working on recovery are seriously lacking for Deaf persons. Lack of accessible AA/NA meetings, difficulty in obtaining a sponsor, lack of accessible communication with sponsors and limited choices for socializing within the Deaf Community point to the shortage of traditional supports. The study also points out the apparent tendency of these clients to be unemployed following treatment. Several explanations can be proposed including a lack of adequate training on the part of the individual, lack of motivation for working (as opposed to being supported by SSI or other forms of public assistance), lack of available jobs, or some form of discrimination based on the Deafness and/or the addiction. It was beyond the scope of this study to predict employment activity in a longer period after treatment. However, it seems that a connection with vocational rehabilitation services would be helpful, particularly if the individual has access to a rehabilitation counselor with some understanding of the disease of chemical dependency.

Relapse Prevention Groups

Just as group work can be very therapeutic in the treatment setting, it can also provide ongoing support and education related to relapse prevention. In order for this kind of group to be successful it needs to have firm rules and boundaries about gossip, confidentiality and chemical use. Education in this area is especially important as the expectation of confidentiality runs counter to the cultural grapevine in the Deaf Community. Confidentiality, however, is essential in building trust. Recovering persons in this kind of group should be encouraged to have several sponsors, possibly including some individuals who are hearing as well as Deaf. In these groups, co-facilitators may serve more in an advisory role and be less directive toward individual members. However, individual therapy outside of the group setting should be encouraged when indicated. Education about the content and nature of feedback is also often necessary. Feedback in this kind of group should include affirmations and comment about individual strengths as well as areas that may be relapse warning signs.

The relapse prevention group leader should also have a clear idea about the topic or goal for each group session. Continued work based on the Twelve Steps of Alcoholics Anonymous helps them continue to access Twelve Step meetings. In addition, the group should provide education about the relapse process, myths about relapse, progression of the disease (chemical dependency), consequences of use, and substitute addictions or compulsions. Group members can be helped to recognize patterns in their behavior, both positive and negative. Identification and utilization of safe places and sober social activities can also happen in the group context. Additional related topics may also be addressed in the group such as: social skills, relationship building, assertiveness skills, decision making/problem solving skills, conflict resolution skills, help seeking skills, independent living skills services and recreational skill development.

Relapse Prevention Materials

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals consistently recommends a strong aftercare program as part of the recovery process. Twelve Step meetings, counseling, obtaining a sponsor, aftercare meetings and other support groups are a part of the aftercare recommendations. However, many Deaf clients return to home areas where there are few if any recovering Deaf people and few if any service providers who are knowledgeable and skilled in working with the assistance of a counselor or therapist. Program staff also continue to develop modified versions of this relapse work to accommodate clients

with varying language levels. To assist in education related to relapse prevention, a variety of relapse activities can be used with clients. It is important for relapse prevention to include what the process of relapse entails and common warning signs. The list of warning signs includes signs described by common AA saying such as "Stinkin' thinkin'". The Minnesota Program gives clients the option to write or draw responses to a variety of activities focusing on when he/she has experienced various relapse signs. Activities that are done with clients also include a discussion about potential disappointments, feeling, urges and thankfulness.

Example 1:
The client is invited to draw or write about how it feels to be sober and to tell about positive and negative feelings.

TREATMENT HIGH means"feeling very good when I leave treatment." Many times people leave treatment feeling very good. This is called a treatment high. People are excited about being sober and new behaviors. We want to help other Deaf people. We want to save the world. Later this feeling may go away. Regular life can make sobriety very hard. Sometimes, after treatment, being sober doesn't feel good. Sometimes we feel sad, lonely, disappointed, depressed, scared or angry.

Another important component of relapse prevention is for the client to deal with feelings, and to understand healthy vs. unhealthy ways of dealing with feelings. Activities to assist clients in understanding these issues can focus on resentments, anger, hurt, loneliness, grief, shame, jealousy and feeling good in recovery. The client is assisted in identifying feeling triggers that could lead to relapse.

Example 2:
The client is asked to write or draw about times he/she felt lonely and to show what was done. The client is asked to identify people that can help when he/she feels lonely.

LONELINESS means feeling like you are by yourself. Being lonely means feeling left out. Being lonely means being isolated. Being lonely means being alone and unhappy about it. Sometimes recovering people feel alone with their problems. We think no one understands how we feel. We forget to talk to other people. We forget to ask for help. We begin to stay away from other people.

Relapse prevention should also focus on beliefs the client has about him or herself. Clients are encouraged to examine what triggers various negative thoughts and how behavior is connected to negative thinking. Clients then work with positive thinking in a similar manner.

Example 3:

Negative beliefs and behaviors can be a sign of relapse. Look at the sentences and then add your own. I think I am a bad person, so I break the law. I feel jealous of my brother, -so I steal his shirt. I'm afraid to meet new people---so I stay home and drink.

Finally, relapse prevention should explore various ways of having fun and maintaining a healthy lifestyle as a sober person. Clients are invited to recall instances of sober fun and to identify some new activities they would like to try by examining skills and interests. Boredom can be a trigger for relapse and activities are used to assist clients to identify those times when boredom is likely to set in. The H.A.L.T. (Hungry, Angry, Lonely, Tired) concept is also explored and ties those factors to sobriety. It is important for clients to be aware of their eating and sleeping patterns and to set goals for changes they would like to make.

Clients are encouraged to develop a prevention plan for relapse summarizing personal relapse warning signs and identifying sources of support for when these triggers emerge. A relapse prevention contract form offers the opportunity for clients to contract with someone they trust, asking for feedback about relapse warning signs.

Encouraging Recovery

Recovery is a lifetime task and while each individual must attend to his/her own recovery, concerned persons can make a contribution to encouraging recovery. The provision of specialized services across the continuum of prevention/education, intervention, treatment and aftercare is an important step. The slowly growing number of accessible AA meetings is also cause for hope. The following proactive suggestions can help to promote recovery as a healthy option.

- Encourage Deaf people to go to general AA area service meetings and become Group Service Representatives as a way of becoming more involved in the structure of AA.
- Provide inservice sessions for hearing leaders in AA to help them understand issues that Deaf people face.
- Encourage Deaf people to go to their area Deaf clubs and organize a "sober night" on a regular basis.
- Encourage deaf people to assist in setting up interpreters for special interest support groups such as for gay/lesbian people, Native persons, African American persons, survivors and so on.
- Encourage Deaf people to advocate for sober living environments such as sober houses or halfway houses.

Conclusion

While treatment is important in intervening in substance abuse, real recovery work begins after treatment. A part of that work involves the recognition and prevention of relapse. Many variables can influence relapse but the lack of accessible resources can be a major factor for Deaf people. Specialized materials which take into account the communication and cultural needs of Deaf persons can positively contribute to the process of recovery. Support services such as aftercare, vocational rehabilitation and self help groups can help to encourage ongoing pursuit of a recovering lifestyle but only if they can be accessed by the Deaf or hard of hearing person. Substance abuse treatment services that meet the communication and cultural needs of Deaf individuals are not enough. A continuum of education, prevention, treatment and aftercare services can help to ensure Deaf people the opportunity for recovery.

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